

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. To funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01345

CERTIFICATE OF DEATH

01303

1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELSTON</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>MEMORIAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>NARCISSA</i>	Middle <i>LEE</i>	Last <i>ADAMS</i>
4. DATE OF DEATH	JAN. <i>16</i>	Month <i>1966</i>	Day Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 30, 1889</i>
9. AGE (In years last birthday) <i>76 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at Home</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>GEORGE NEIGHBORS</i>	14. MOTHER'S MAIDEN NAME <i>VIRGINIA BECK</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>MRS VIRGINIA RASH, DENTON, MD.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH <i>1-9-66</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <i>7A-M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Trever</i>		22b. DATE SIGNED <i>1/16/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Easton, Md.</i>
23a) BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL Jan 18 1966</i>	23b. DATE THEREOF <i>Jan 18 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>	23d. LOCATION (City, town or county) (State) <i>Caroline Co. Md.</i>
24. FUNERAL DIRECTOR <i>H. K. Moore Denton</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>JAN 21 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

50010

50010

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
01346				01304								
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>				c. LENGTH OF STAY IN 1b <i>18</i>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>MEMORIAL HOSPITAL</i>				e. STREET ADDRESS <i>DENTON 05-2</i>								
3. NAME OF DECEASED (Type or print) <i>GRACE L. BOWOLE</i>				First <i>GRACE</i>	Middle <i>L.</i>	Last <i>BOWOLE</i>	4. DATE OF DEATH Month <i>1</i>	Day <i>27</i>	Year <i>1966</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/29/1880</i>	9. AGE (In years last birthday) <i>85 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>WILLIAM H. MEREDITH</i>				14. MOTHER'S MAIDEN NAME <i>SARAH SMITH</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.				17. INFORMANT				Address <i>MRS. JOSEPH HARRINGTON, DENTON</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage with left hemiplegia</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>8 days</i> (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>19 Jan 1966</i> , to <i>27 Jan 1966</i> , that (I) (we) last saw the deceased alive on <i>27 Jan 1966</i> , and that death occurred at <i>12pm</i> M, from the causes and on the date stated above.												
22a. SIGNATURE <i>Rutherford Garrison</i>				22b. DATE SIGNED <i>28 Jan 66</i>								
22c. PHYSICIAN'S NAME (Type) <i>THORSTON GARRISON</i>				22d. ADDRESS <i>EASTON, MARYLAND</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>FEB. 1, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>DENTON</i>		23d. LOCATION (City, town or county) <i>DENTON MD.</i>				
24. FUNERAL DIRECTOR <i>J. Virgil Moorehead</i>				ADDRESS <i>Denton 240</i>								
25a. REC'D BY REGISTRAR <i>DATE FEB 2 1966</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock - Rural</i>								
c. LENGTH OF STAY IN 1b <i>4 1/2 hr.</i>												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hosp. Tal</i>				d. STREET ADDRESS <i>Near Elwood</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Angel</i>	Middle <i>Makio</i>	Last <i>Briggs</i>	4. DATE OF DEATH <i>July 12, 1965</i>	Month <i>July</i>	Day <i>13</i>	Year <i>1966</i>				
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 12, 1965</i>	9. AGE (In years last birthday) yrs. <i>6</i>	10. UNDER 1 YEAR Months <i>0</i>	11. UNDER 24 HRS. Days <i>13</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Easton, Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Luis Chanza</i>				14. MOTHER'S MAIDEN NAME <i>Virginia Briggs</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Virginia Briggs, Hurlock, Maryland, RFD</i>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemic Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Underlying cause last. (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <i>1125</i> M, from the causes and on the date stated above.				22b. DATE SIGNED <i>1/14/66</i>								
22a. SIGNATURE <i>Charles H. Hartfield</i>				22b. DATE SIGNED <i>1/14/66</i>								
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Jan. 17, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Washington Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Near Hurlock, Maryland</i>				
24. FUNERAL DIRECTOR <i>James Dauplaise, Jr. Federalburg, Maryland</i>				25a. REC'D BY REGISTRAR <i>JAN 18 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01348

CERTIFICATE OF DEATH

01306

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MARYLAND</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>6:50 pm - 8pm</i>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>	e. STREET ADDRESS <i>203 S. Hanson</i>
78	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <i>WALTER</i>	Middle <i>Fendy</i>	Last <i>Conneyes</i>	4. DATE OF DEATH Month <i>1</i>	Day <i>5</i>	Year <i>1966</i>
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5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG 4, 1897</i>	9. AGE (In years last birthday) <i>68 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. HOURS Hours <i>0</i>	13. MIN. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Interior Decorator</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Queen Anne, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>James Conneyes</i>	14. MOTHER'S MAIDEN NAME <i>Susan Hassett</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>216-09-5081</i>	17. INFORMANT <i>Mrs. W. F. Conneyes</i>	Address <i>203 S. Hanson St. Easton, Md.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>	INTERVAL BETWEEN ONSET AND DEATH <i>May</i>
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4201	DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)	DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)
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20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>	20f. (City or town) (County) (State)
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21. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>65</i> , to <i>July</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5 pm</i> 19 <i>66</i> , and that death occurred at <i>8 p.m.</i> from the causes and on the date stated above.

22a. SIGNATURE <i>Thorston Harrison</i>	22b. DATE SIGNED <i>July 66</i>
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22c. PHYSICIAN'S NAME (Type) <i>Thorston Harrison</i>	22d. ADDRESS <i>Easton, Maryland</i>
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23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Jan 8, 66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardiner Memorial</i>	23d. LOCATION (City, town or county) (State) <i>At 500 Cedar</i>
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24. FUNERAL DIRECTOR <i>John Clark</i>	ADDRESS <i>Easton, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 10 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
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1000 ft. above sea level

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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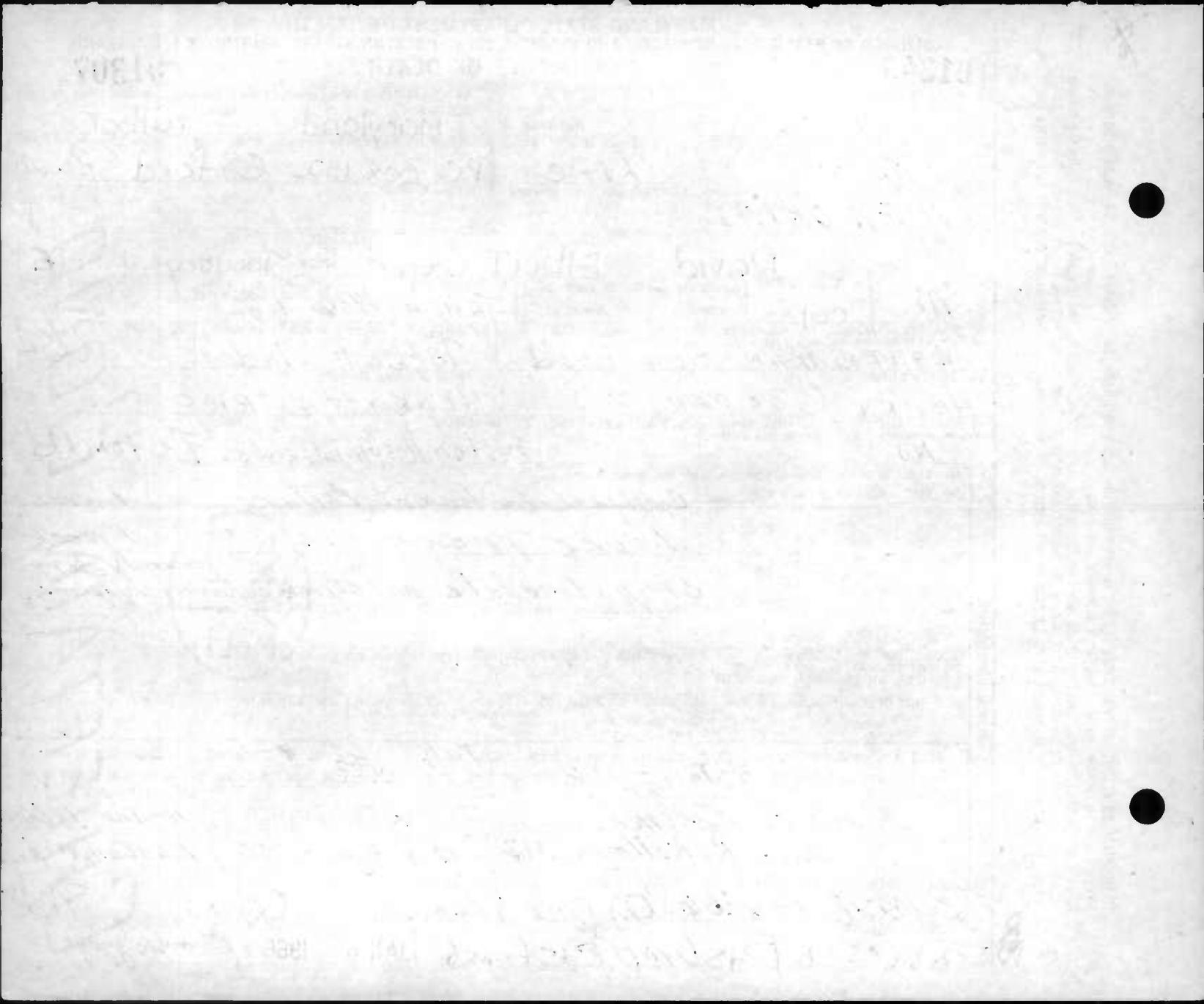
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01349

01307

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Box 132, Oxford Rural	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL		1. STREET ADDRESS 20-1	
3. NAME OF DECEASED First David Middle Elbert Last Cooper		4. DATE OF DEATH Month January Day 4 Year 1966	
5. SEX M		6. COLOR OR RACE Col	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 4, 1906	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY Sea Food	
11. BIRTHPLACE (County & State, or foreign country) Talbot Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Cooper		14. MOTHER'S MAIDEN NAME HENRIETTA PRICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Address	
17. INFORMANT Easton Hosp. Tel Records		INTERVAL BETWEEN ONSET AND DEATH 1 week	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobar pneumonia DUE TO Several years (c) cor pulmonale and chronic pulmonary emphysema			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1963 to 4-Jan 1966 , that (I) (we) last saw the deceased alive on 4-Jan - 1966 , and that death occurred at Oxford M, from the causes and on the date stated above.		22b. DATE SIGNED 4-Jan-1966	
22a. SIGNATURE Dale R Kollman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dale R. Kollman, M.D.		22d. ADDRESS 12 N. Hanson St.; Easton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-8-66	
23c. NAME OF CEMETERY OR CREMATORIAL Oxford Neck Cem.		23d. LOCATION (City, town or county) Oxford (State) Md.	
24. FUNERAL DIRECTOR James B. Dashiell		ADDRESS 111 Easton	
25a. REC'D BY REGISTRAR JAN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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01350

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01308

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Talbot</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>12 hrs</i>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	d. STREET ADDRESS <i>315 South St.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Perry</i>	Middle <i>Albert</i>	Last <i>Copper</i>	4. DATE OF DEATH <i>1-30-66</i>	Month <i>1</i>	Day <i>30</i>	Year <i>66</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-4-20</i>	9. AGE (in years last birthday) <i>48 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Jacot Copper

11. BIRTHPLACE (County & State, or foreign country)
Talbot, Md.

12. CITIZEN OF WHAT COUNTRY?
USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
yes WW II

16. SOCIAL SECURITY NO. 17. INFORMANT
218-03-7951 Harriet Copper

Address
Easton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

(b)

DUE TO

cause (a), stating the underlying cause last.

(c)

Pulmonary hemorrhage

Bronchogenic carcinoma

INTERVAL BETWEEN ONSET AND DEATH

5 min.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from *Jan. 11, 1966*, to *Jan. 20, 1966*, that (I) (we) last saw the deceased alive on *Jan. 20, 1966*, and that death occurred at *10 AM*, from the causes and on the date stated above.

22a. SIGNATURE <i>Dale R Kollman</i>	22b. DATE SIGNED <i>20-Jan-1966</i>
22c. PHYSICIAN'S NAME (Type) <i>D. Kollman, M.D.</i>	22d. ADDRESS <i>Easton, Maryland</i>

23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>1-24-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Richards Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Easton Md.</i>
24. FUNERAL DIRECTOR <i>James B Dashiel</i>	ADDRESS <i>Easton, Md.</i>	25a. REC'D BY REGISTRAR <i>James B Dashiel</i>	25b. REGISTRAR'S SIGNATURE <i>James B Dashiel</i>

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01351

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01309

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>48 min.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Eddie</i>	Middle <i></i>	Last <i>Cullison</i>	
4. DATE OF DEATH <i>1/24/66</i>	Month <i>1</i>	Day <i>24</i>	Year <i>66</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22, 1901</i>	
9. AGE (in years last birthday) <i>64 yrs.</i>	FUNDER 1 YEAR Months <i></i>	FUNDER 24 HRS. Days <i></i>	Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Oyster shucker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Sea Food</i>	11. BIRTHPLACE (County & State, or foreign country) <i>St. Mary's Co. Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Cullison</i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>	Address <i>Mrs. Mary Christian - Grasonville</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>216-38-9261</i>	17. INFIRMITY <i></i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arterial Status</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 day</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>1/24</i> , 19 <i>66</i> , to <i>1/24</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/24</i> , 19 <i>66</i> , and that death occurred at <i>474</i> M, from the causes and on the date stated above.	22a. SIGNATURE <i>C. R. Layton</i>	22b. DATE SIGNED <i>1-27-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>C. R. Layton</i>	22d. ADDRESS <i>Centreville, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>JAN. 27, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>CHESTER Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Chester Maryland</i>	
24. FUNERAL DIRECTOR <i>James H. Layton, Layton Bros. Cremation, Maryland</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i></i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>FEB 1 1966</i>		DATE <i>FEB 1 1966</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>27 days/6½ yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sarah Catherine Dobson</i>		First <i>Sarah</i>	Middle <i>Catherine</i>
4. DATE OF DEATH Last <i>Dobson</i>		Month <i>JAN</i>	Day <i>7</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>3/23/1880</i>		9. AGE (in years last birthday) <i>85</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>B. Harrison Barnard</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Neighbors</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>unkn.</i>		17. INFORMANT Address <i>Walter H. Dobson, St. Michaels, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1533</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>12-9, 1965, to 1-7, 1966</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>St. Michaels, MD.</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>12-9, 1965</i> , to <i>1-7, 1966</i> , that (I) (we) last saw the deceased alive on <i>12-9, 1965</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>1-8-66</i>	
22c. SIGNATURE <i>R. Paul Whitham</i>		22d. ADDRESS <i>St. Michaels, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/11/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Oxford Cemetery</i>
23d. LOCATION (City, town or county) (State) <i>Oxford, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 12 1966</i>	
24. FUNERAL DIRECTOR <i>Maurice E. Neumann</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event of removal, within 72 hours after death.

01353

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02841

1. PLACE OF DEATH
a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

EASTON

c. LENGTH OF STAY IN 1b

10 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MEMORIAL HOSPITAL

3. NAME OF
DECEASED
(Type or print)First
LILLIE

Middle

Last
DYER4. DATE
OF
DEATH

1 29 19 66

5. SEX

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

July 15, 1893

9. AGE (in years
last birthday)

72 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Sattlefield

14. MOTHER'S MAIDEN NAME

Priscilla Baynard.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Lydia Green, Denton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ventricular fibrillation

INTERVAL BETWEEN
ONSET AND DEATH

<5 min.

4201

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

Coronary insufficiency

10 days

arteriosclerotic heart disease

Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

R. Trevor

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

James B. Dashell/Easton, Md.

FEB 10 1966

Charles Judge

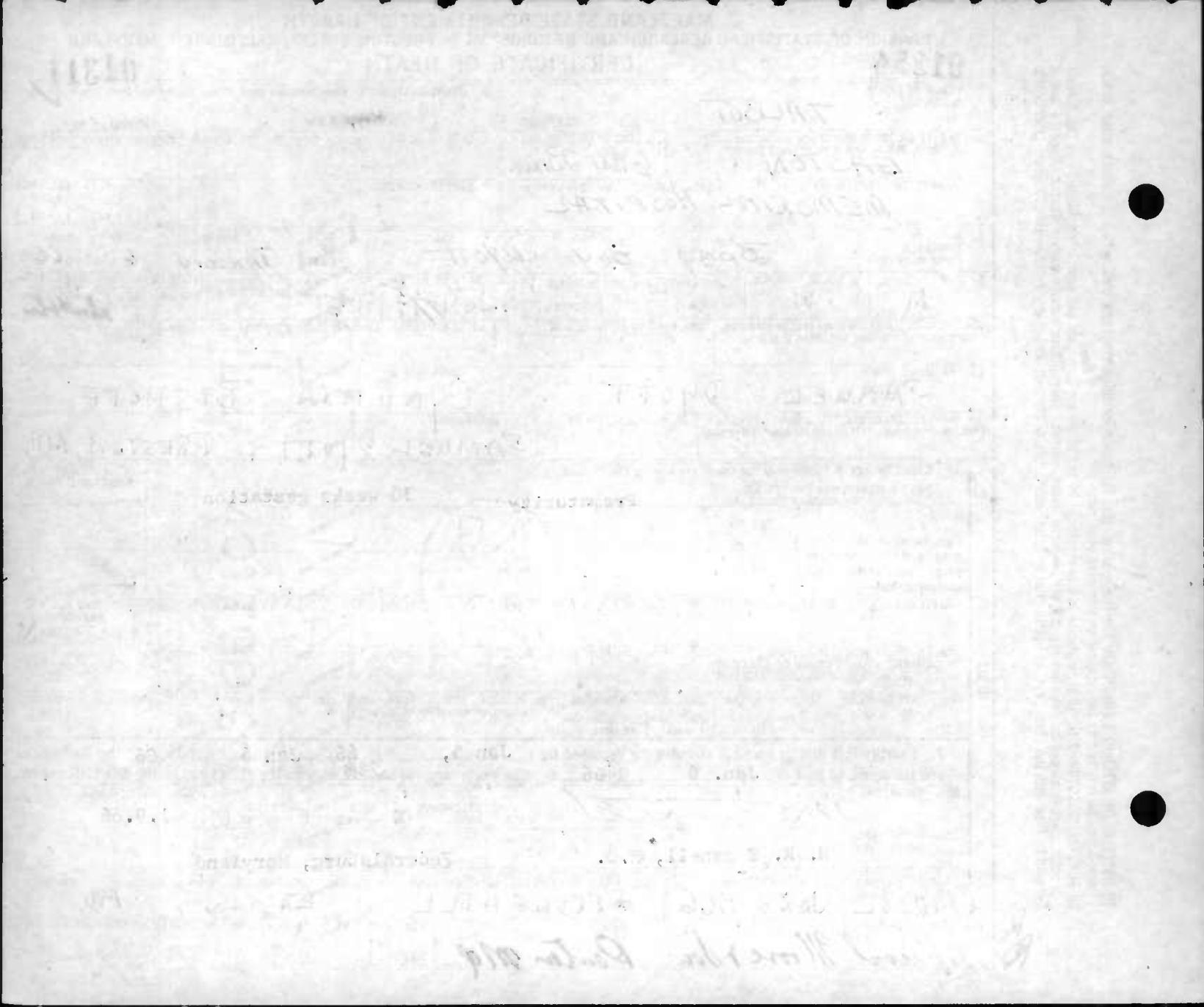
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
TALBOT MARYLAND				Md. Caroline								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b 6 hr 23 min								
EASTON				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston 05-2								
d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address)				d. STREET ADDRESS								
MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First Baby	Middle Boy	Last DYOTT	4. DATE OF DEATH	Month JANUARY	Day 6	Year 1966			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 5, 1966	9. AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. CITIZEN OF WHAT COUNTRY?	14. IN MONTHS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME SAMUEL DYOTT			14. MOTHER'S MAIDEN NAME CYNTHIA BISHOFF			Address			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT SAMUEL DYOTT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) OUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 weeks gestation			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1966, to Jan 6, 1966, that (I) (we) last saw the deceased alive on Jan. 6 1966, and that death occurred at 238 M, from the causes and on the date stated above.			
MEDICAL CERTIFICATION			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
22a. SIGNATURE H. R. Tapnell, M.D.			22b. DATE SIGNED 1.9.66			21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1966, to Jan 6, 1966, that (I) (we) last saw the deceased alive on Jan. 6 1966, and that death occurred at 238 M, from the causes and on the date stated above.			22c. PHYSICIAN'S NAME (Type) H. R. Tapnell, M.D.		22d. ADDRESS Federalsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan 8, 1966			23c. NAME OF CEMETERY OR CREMATORIAL SPRING HILL			23d. LOCATION (City, town or county) (State) EASTON, MD.			
24. FUNERAL DIRECTOR J. Tapnell, Denton, Md.			ADDRESS 61-160792			25a. REC'D BY REGISTRAR DATE UN 13 1966			25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 20M 1/65												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01355

CERTIFICATE OF DEATH

01312

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>		b. COUNTY <i>Talbot</i>	
c. LENGTH OF STAY IN 1b <i>9 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>00</i>		d. STREET ADDRESS <i>20 - 1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Martha Pier Easterbrook</i>	Middle	Last <i>1/15 1966</i>
4. DATE OF DEATH Month <i>1/15</i>	Day <i>19</i>	Year <i>66</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. OATE OF BIRTH <i>12/4/1886</i>
9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDERR 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Edward J. Carpenter</i>	14. MOTHER'S MAIDEN NAME <i>Martha Pier</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>074-18-0051</i>	17. INFORMANT <i>Mrs. Thelma E. Howell, Beachwood, N.J.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Occlusion</i>		INTERVAL BETWEEN DNSETE AND DEATH <i>4 d.</i>	
332 X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, generalized</i>		DUE TO (c) <i>4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Dec 1965</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i>19</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton, Md.</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 1965</i> to <i>1/15 1966</i> that (I) (we) last saw the deceased alive on <i>Jan 1966</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>S. Kreck Jr.</i>		22b. DATE SIGNED <i>1-17-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>S. Kreck, Jr.</i>	22d. ADDRESS <i>Easton, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>1/17/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Green Mount</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR <i>MURKIE E. NEUNAM & SON, Easton, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>JAN 18 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01313

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)	
<i>Albot</i>		a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Easton</i>		14 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
<i>The Memorial Hosp. Inc.</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Dorothy Dean</i>		<i>Fountain</i>	Last
4. DATE OF DEATH		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>		None	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Harvey H. Dean</i>		<i>Margaret Boyle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
No		169-18-1311 Jayne Parncutt Boothwyn, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>ASCITES, ANEURA.</i>	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO <i>CARCINOMA OF THE STOMACH</i> 3 MO	
(b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 1965</i> to <i>Jan 1966</i> , that (I) (we) last saw the deceased alive on <i>1-12 1966</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>1/14/66</i>	
22a. SIGNATURE <i>H. M. Walsh MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1/14/66</i>
22c. PHYSICIAN'S NAME (Type) <i>H. M. Walsh</i>		22d. ADDRESS <i>M. D. Easton, Maryland</i>	23d. LOCATION (City, town or county) (State) <i>Denton, Maryland</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-16-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Denton</i>
24. FUNERAL DIRECTOR <i>J. E. Boulaire Greensboro, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>JAN 17 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

Certificate be executed within 24 hours after death.

g physician and completely filled in by the funeral
then please remove carbon papers. Pages 1 and 2
removal, and in any event, within 72 hours after death.

visit permit. T

MEDICAL CERTIFICATION

Certificate be executed within 24 hours after death.

g physician and completely filled in by the funeral
then please remove carbon papers. Pages 1 and 2
removal, and in any event, within 72 hours after death.

visit permit. T

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
01357				01314									
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>23 day 5 hrs</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hosp at Easton</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Fanny Ellington Deeney</i>		First	Middle	Last	4. DATE OF DEATH <i>Dec 1966</i>	Month	Day	Year					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 13 1906</i>	9. AGE (in years last birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/>	11. IF UNDER 24 HRS <input type="checkbox"/>	Months	Days	Hours		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Case Worker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Co. Welfare Board</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Virginia USA</i>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James E. Ellington</i>				14. MOTHER'S MAIDEN NAME <i>Mattie Morrison</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-12-4765</i>				17. INFORMANT <i>William S. Denny, Easton, Md.</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Cirrhosis</i>				5810				INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i>					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Liver failure</i>				DUE TO				3 mos					
(c) <i>Cirrhosis of the liver</i>				DUE TO				—					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <i>Easton, Md.</i> (County) <i>Easton, Md.</i> (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> , 19, to <i>1-1</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan 1 1966</i> , and that death occurred at <i>5pm</i> M, from the causes and on the date stated above.													
22a. SIGNATURE <i>Maurice A. Neesam</i>				22b. DATE SIGNED <i>1-3-66</i>									
22a. PHYSICIAN'S NAME (Type) <i>Maurice A. Neesam</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22d. ADDRESS <i>40 Michaels Rd</i>				22d. ADDRESS <i>40 Michaels Rd</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1/4/1966</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Memorial Park</i>				23d. LOCATION (City, town or county) <i>Easton, Md.</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Maurice A. Neesam, 40 Michaels Rd, Easton, Md.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 15M 4-64				DATE <i>JAN 6 1966</i>									

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mineral base until 100% carbonated

minerals added until 100%

100% mineral water 20-25% 60%

water 100% mineral water 100% water

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01358

01315

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Talbot MARYLAND		Maryland Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
Wittman	Life		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
(Blank space)			
3. NAME OF DECEASED (Type or print)		First	Middle
MARY HESTER HADDAWAY			
4. DATE OF DEATH		Month	Day
January 9, 1966		Month	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
Sept 29, 1898		67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife			
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Talbot County, Md.		USA	
13. FATHER'S NAME			
James H. Fairbank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		215-16 8825 Ella Kerper Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, immediately 4201 DUE TO coronary occlusions - Conditions, if any, which gave rise to immediate cause (b) - { (a), stating the underlying cause last. DUE TO (c) other occlusive coronary and			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED p.m. 19 White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955, 1960 to 1966, that (I) (we) last saw the deceased alive on 11-30 1965, and that death occurred at 2 PM, from the causes and on the date stated above.			
22e. SIGNATURE <i>Guy M. Reeser</i>		22b. DATE SIGNED 1-11-66	
22e. PHYSICIAN'S NAME (Type) GUY M. REESER, Jr., M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS St. Michaels, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 12, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Easton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hamletton Harrison, St. Michaels, Md.</i>		25a. REC'D BY REGISTRAR JAN 13 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) ISM 7/61			

STANFORD TRINITY HIGH SCHOOL
STANFORD, CALIFORNIA
THE STANFORD TRINITY HIGH SCHOOL
HONOR CODE
APPROVED BY THE BOARD OF TRUSTEES
APRIL 19, 1956

ARTICLE I
INTEGRITY

ARTICLE II
HONESTY

ARTICLE III
RESPECT FOR OTHERS

ARTICLE IV
COURTESY

ARTICLE V
FAIRNESS

ARTICLE VI
DILIGENCE

ARTICLE VII
DISCIPLINE

ARTICLE VIII
LOYALTY

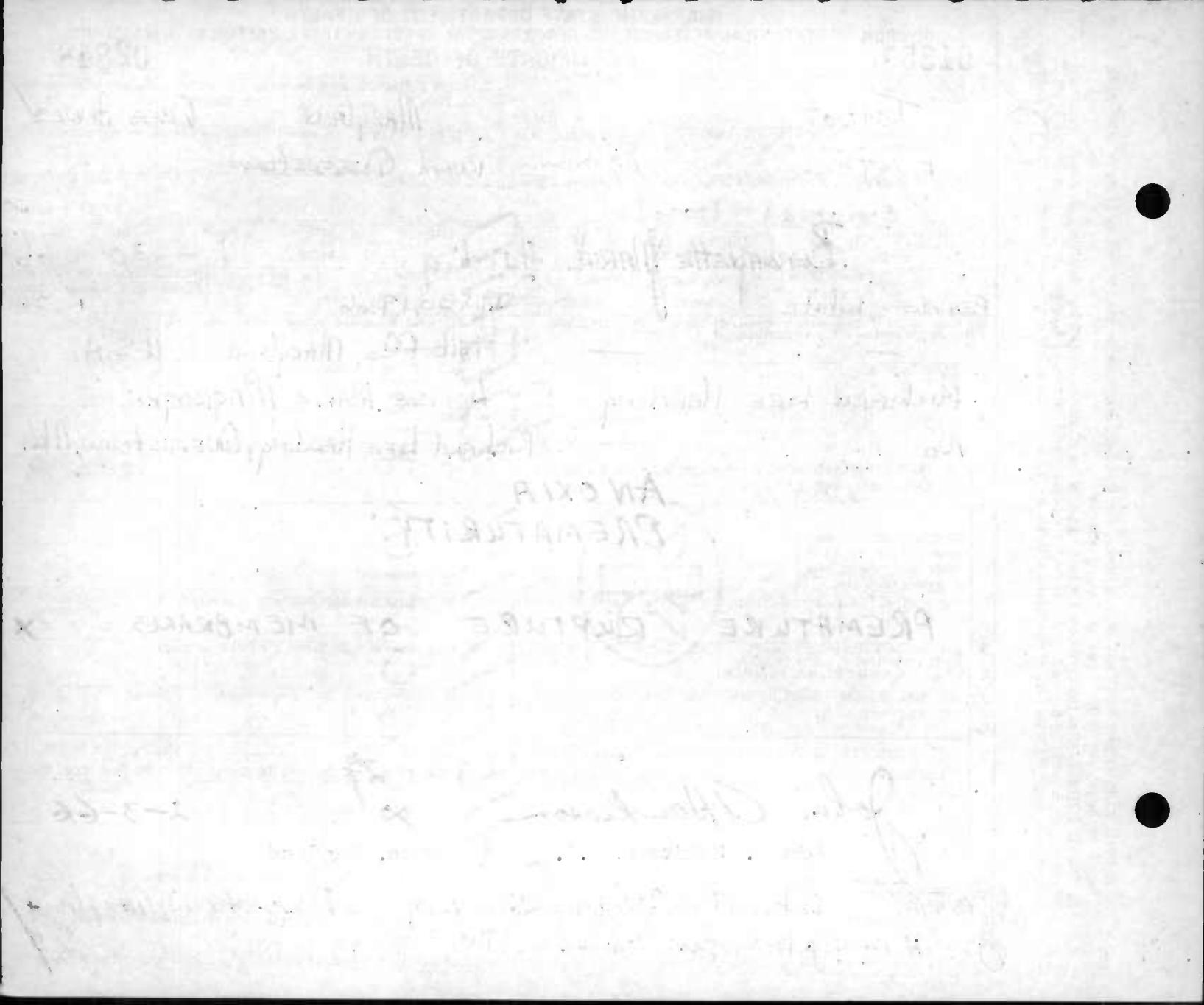
ARTICLE IX
CHARACTER

ARTICLE X
HONOR

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

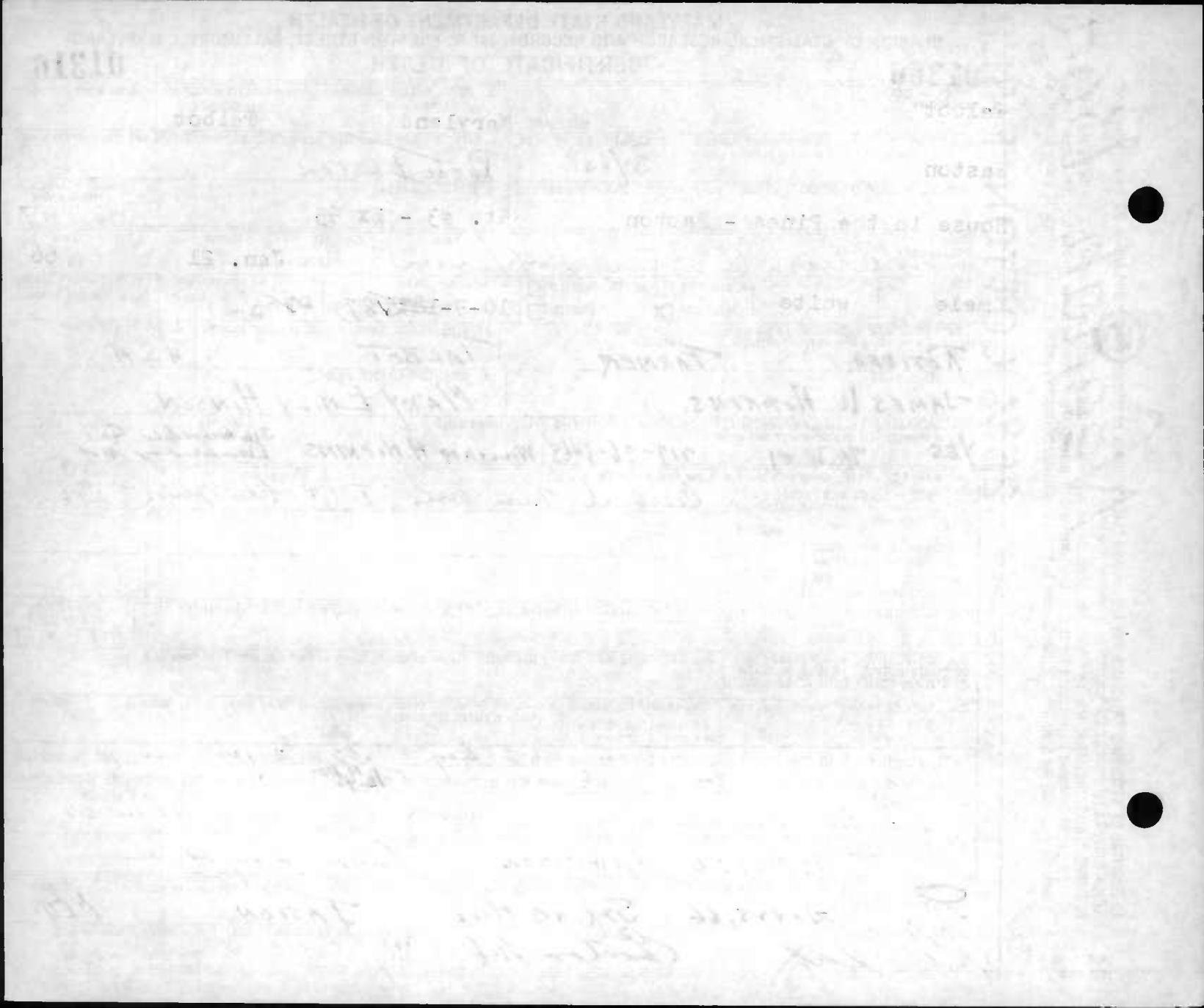
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												02848		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
Talbot			b. STATE			Maryland			b. COUNTY			Queen Anne's		
MARYLAND			c. LENGTH OF STAY IN 1b			88 min.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rural Queenstown		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?					
Easton			Memorial Hospital						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year					
BERNADETTE MARIE Harding						JAN. 30, 1966			1 - 30 19 66					
5. SEX			6. COLOR OR RACE			7. MARRIED			8. DATE OF BIRTH			9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.		
FEMALE			White			NEVER MARRIED <input checked="" type="checkbox"/>			JAN. 30, 1966			Months Days Hours Min.		
WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>									, , , 28		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
						Talbot Co Maryland			U.S.A.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address								
Richard Lee Harding			Louise Marie Magrogan											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
									AN OXIA PREMATURITY					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PREMATURE RUPTURE OF MEMBRANES											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PREMATURE RUPTURE OF MEMBRANES			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			19											
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 230 M, from the causes and on the date stated above.														
22a. SIGNATURE John A. Hawkinson, M.D.									22b. DATE SIGNED 2-3-66					
22c. PHYSICIAN'S NAME (Type)			John A. Hawkinson, M.D.			22d. ADDRESS Easton, Maryland								
23a. BURIAL / CREMATION, REMOVAL (Specify)			23b. DATE THEREOF Feb. 1, 1966			23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cemetery			23d. LOCATION (City, town or county) Queensland, Maryland			(State)		
24. FUNERAL DIRECTOR James H. Beaton Jr., Beaton Bros. Crematory, Md.			ADDRESS			25a. REC'D BY REGISTRAR FEB 10 1966			25b. REGISTRAR'S SIGNATURE Charles Judge					
B-160702														



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		01316					
1. PLACE OF DEATH Talbot County				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) MARYLAND Maryland				a. STATE Talbot				b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 3 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON				d. STREET ADDRESS Rt. #3 - BX 95				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines - Easton				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. #3 - BX 95				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. #3 - BX 95				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. #3 - BX 95				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Walter Hopkins				First	Middle	Last		4. DATE OF DEATH Jan. 21 1966				Month	Day	Year					
5. SEX male		6. COLOR OR RACE white		7. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED		8. DATE OF BIRTH 10-9-1887				9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 3		11. IF UNDER 24 HRS. Days 92			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY FARMER				11. BIRTHPLACE (County & State, or foreign country) TALBOT				12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME JAMES W. HOPKINS				14. MOTHER'S MAIDEN NAME MARY EMILY HINSON				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES. W.W.I				16. SOCIAL SECURITY NO. 717-36-1468				17. INFORMANT WILLIAM H. HOPKINS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X				DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)				DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH Central Mem. Hosp. e (R) semi-phys 27 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 23 day , 19 63 to 24 Jan , 19 66 , that (I) (we) last saw the deceased alive on 21 Jan , 19 66 , and that death occurred at 10 AM , from the causes and on the date stated above.												22b. DATE SIGNED 22 Jan 66							
22a. SIGNATURE Thorston Harrison				22b. ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>				22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS Easton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				23b. DATE THEREOF JAN 25, 66				23c. NAME OF CEMETERY OR CREMATORIAL SPRING HILL				23d. LOCATION (City, town or county) EASTON				(State) MD			
24. FUNERAL DIRECTOR Willie Clark				ADDRESS Easton Md.				25a. REC'D BY REGISTRAR DATE JAN 25 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01361

01317

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove two papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>Stone</u> <u>Riv Vista Nursing Home</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Easton</u> <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> Md. / month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>210 Goldsborough St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u>		First <u>Helen</u>	Middle <u>Imbody</u>
4. DATE OF DEATH <u>Jan. 6 1966</u>	Last <u>I</u>	Month <u>Jan.</u>	Day <u>6</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 13 - 1894</u>
8. AGE (In years last birthday) <u>71 yrs.</u>	9. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	10. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mc. Gunk</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Du Bois</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>7</u>	
17. INFORMANT <u>Records Riv Vista Nursing Home</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>1750</u> DUE TO <u>Infection</u> INTERVAL BETWEEN ONSET AND DEATH <u>1962</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancerous tumor</u> (c) <u>Carcinomatosis ovarian</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>Diabetes</u> <u>Body will be sent to anatomy board Md.</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>1/1/1966</u>	
20c. TIME OF INJURY Hour a.m. <u>19</u>	Month, Day, Year p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Easton</u> (County) <u>Md.</u> (State) <u>Md.</u>
21. I certify that (I) (<u>J.T.B. Ambler</u>) attended the deceased from <u>March</u> , 19 <u>63</u> to <u>1/6/66</u> , 19 <u>66</u> , that (I) (<u>J.T.B. Ambler</u>) last saw the deceased alive on <u>1/1/1966</u> , and that death occurred at <u>358</u> from the causes and on the date stated above.		22a. SIGNATURE <u>J.T.B. Ambler</u> M.D.	
22c. PHYSICIAN'S NAME (Type) <u>J.T.B. AMBLER</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/6/66</u>
23a. BURIAL CREMATION REMOVAL (Specify) <u>2</u>		23b. DATE THEREOF <u>1/7/66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Anatomy Board of Md.</u>
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		(State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hambleton Harrison, St. Michaels</u>		ADDRESS <u>Box 1025</u>	25a. REC'D BY REGISTRAR <u>J. Charles J. George</u>
		25b. REGISTRAR'S SIGNATURE	DATE <u>JAN 10 1966</u>

6211

3820

R23

201

Small greenish brown

yellow

more or less rounded

blood positive at following sites

adult male dorsal

Shrub

small reddish brown

with some yellowish brown

3000 ft. elev. 2000 ft. elev.

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
Talbot				Md									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1D MARYLAND									
EASTON				1 hr 25 min									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS									
Memorial Hospital				RFD I									
3. NAME OF DECEASED (Type or print)				First	Middle	Last	JR.	4. DATE OF DEATH	Month	Day	Year		
James				W.M.	Ivens			8/9/1902	63	1	10	1966	
5. SEX				6. COLOR OR RACE		7. MARRIED		NEVER MARRIED	<input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.	
MALE				WHITE		WIDOWED		DIVORCED	<input type="checkbox"/>	8/9/1902	63	0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY									
Ref Md Game Comm				11. BIRTHPLACE (State or foreign country)									
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?									
JAMES WM IVENS SR				KENT CO MD U.S.A									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO				217-36-2087		217-36287		Mrs. Daisy Ivens					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x													
Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last.				OUE TO (b)	Gun shot wound of Centre forehead				INTERVAL BETWEEN ONSET AND DEATH 3 hours				
				OUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Self Inflicted Gun shot								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:45 p.m. 1:10 1966				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
						Home		Wye Mills Q.A.Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>C.H. Layton</i>													
EXAMINER'S NAME (Type) <i>C.H. Layton</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 13, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		23d. LOCATION (City, town or county) Chestertown, Md.					
24. FUNERAL DIRECTOR				ADDRESS Chestertown, Md.									
VR AISM (5) 5M 1/65				25a. REC'D BY REGISTRAR JAN 12 1966									
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

91316

Nov 21 1911 8

Grand Island
Brachysomus

Collected by Mr. H. C.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			
01363			01319												
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE											
Talbot				Md.				b. COUNTY Talbot							
MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
EASTON				life				Easton							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21 Higgins St.				21 Higgins St.											
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
Mary				Thomas	Johnson	Jan	15	1966							
5. SEX				6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
Female Negro				WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Aug. 2, 1885	80 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY			
none								Talbot, Md				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
William Thomas				Anne Sherwood											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
no								Sarah Pritchett				Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Heart Failure												INTERVAL BETWEEN ONSET AND DEATH 1 Mo.			
IMMEDIATE CAUSE (a) 443 X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.												years			
DUE TO (b) Hypertensive Cardiovascular Disease												months			
DUE TO (c) Generalized Atherosclerosis															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 12, 1965, to Jan 16, 1966, that (I) (we) last saw the deceased alive on Jan 14, 1966, and that death occurred at 8:30 AM, from the causes and on the date stated above.												22b. DATE SIGNED 1-17-66			
22a. SIGNATURE Richard F. Tyson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/>				STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Richard F. Tyson M.D.				22d. ADDRESS 36 South Aurora St. Easton, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 1-19-66				23c. NAME OF CEMETERY OR CREMATORIAL Richards Cemetery				23d. LOCATION (City, town or county) Easton, Md.			
24. FUNERAL DIRECTOR James S. Cashell				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
												DATE FEB 1 1966			
												Signature			

23-81-1

mgk. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

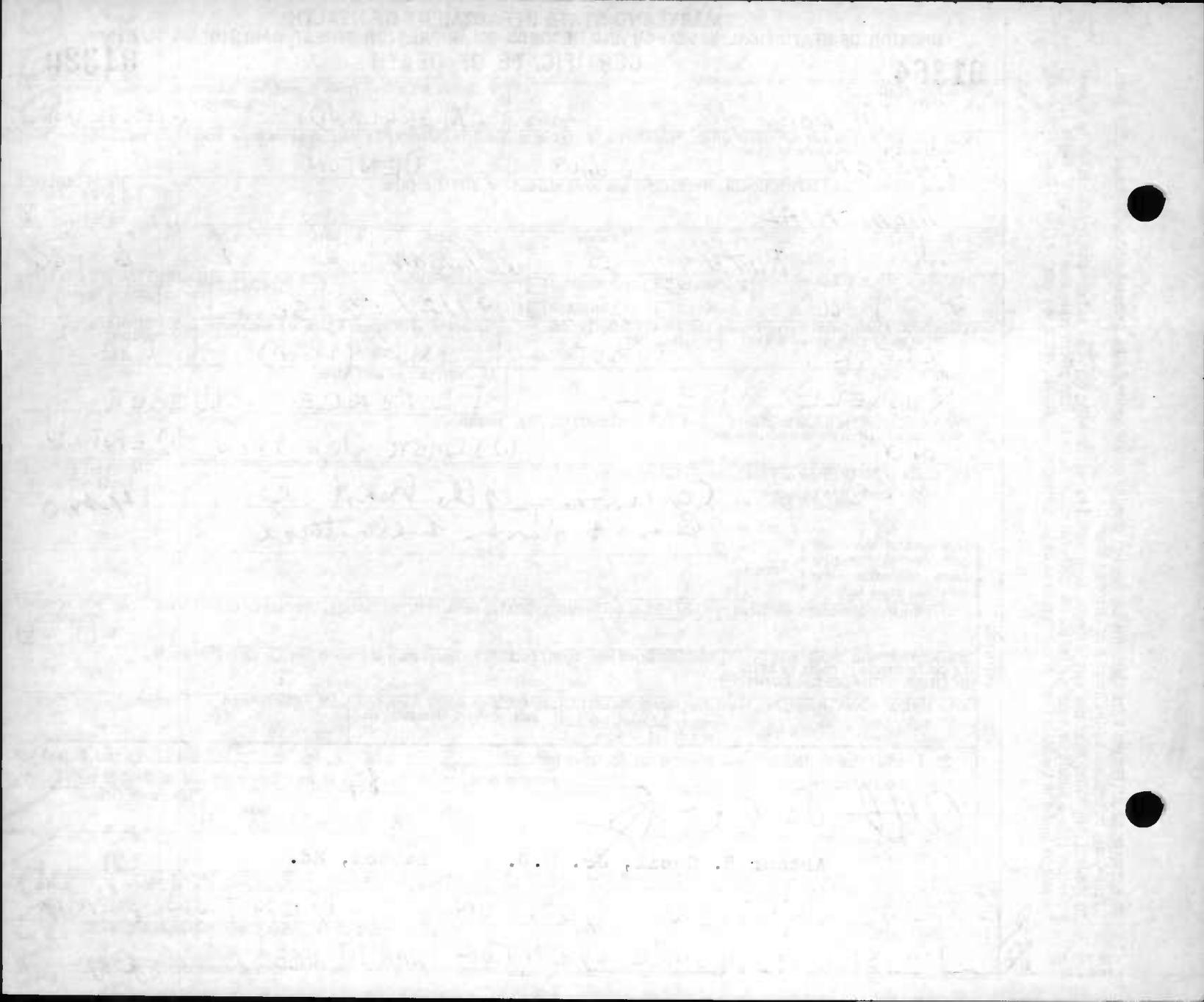
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01364

01320

1. PLACE OF DEATH a. COUNTY		TALBOT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		EASTON		c. LENGTH OF STAY IN 1b		a. STATE MARYLAND b. COUNTY CAROLINE					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		MEMORIAL		8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON 05-2					
3. NAME OF DECEASED (Type or print)		First RUTH	Middle B	Last JOHNSON	4. DATE OF DEATH	Month 1	Day 6	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX F		6. COUNTRY OF RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/07	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK			10b. KIND OF BUSINESS OR INDUSTRY TYPIST			11. BIRTHPLACE (County & State, or foreign country) MD BY LAND					
13. FATHER'S NAME RUSSELL BELL			14. MOTHER'S MAIDEN NAME FLORENCE WEBER			Address WILM BUR JOHNSON, DENTON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X			DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			DUE TO Bones & tissue malignant			INTERVAL BETWEEN ONSET AND DEATH 4 mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 11:55 P.M. from the causes and on the date stated above.									22b. DATE SIGNED		
22a. SIGNATURE									22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS					
Arthur B. Cecil, Jr. M.D.						Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF JAN. 10, 1966			23c. NAME OF CEMETERY OR CREMATORIUM DENTON			23d. LOCATION (City, town or county) DENTON MD (State)		
24. FUNERAL DIRECTOR			ADDRESS J. V. COATE MOORE DENTON			25a. REC'D BY REGISTRAR JAN 11 1966			25b. REGISTRAR'S SIGNATURE J. Charles Judge		
VR A15 (4) 15M 4-64											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01365		Items #8 & 9 Film #0372-27166		02854					
1. PLACE OF DEATH 2. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
Talbot				a. STATE	MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	Talbot				
EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		24 Higgins St.		d. STREET ADDRESS					
William		ARTHUR JOHNSON		e. IS RESIDENCE ON A FARM?					
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE DF DEATH	Month Day Year				
Male		Ne GRO	WIDOWED	Feb. 28	1966				
6. COLOR OR RACE		7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				
Ne GRO		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Feb. 28 1887	81 yrs. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?					
LABORER		DOMESTIC		Caroline Md. USA					
13. FATHER'S NAME		John Robert Johnson		14. MOTHER'S MAIDEN NAME					
John Robert Johnson				Julia A. Foster					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		None Hospital Records		Easton Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CONGESTIVE HEART FAILURE Unknown							
253X		DUE TO	UNKNOWN						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	UNKNOWN						
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?			
GENERALIZED ARTERIOSCLEROSIS						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
19									
21. I certify that (I) this hospital attended the deceased from 13 July 1965 to 31 Jan 1966, that (we) last saw the deceased alive on 24 Jan 1966, and that death occurred at 7A M, from the causes and on the date stated above.						22b. DATE SIGNED			
22a. SIGNATURE						22b. DATE SIGNED			
Richard F. Tyson						2 Feb 66			
22c. PHYSICIAN'S NAME (Type)		M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	EASTON
RICHARD F. TYSON			22d. ADDRESS	36 AURORA ST. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county)				(State)	
Burial		2-5-66	RICHARD'S CEMETERY	EASTON				MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
James B. Washell		Easton, Md.		DATE	EEB 10 1966	Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01366

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01321

1		2. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
		Talbot		MARYLAND		a. STATE Maryland		b. COUNTY Caroline	
78		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		EAsbn		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
		22 da		Federalsburg		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ida		Middle Victoria		Last Jones		4. DATE OF DEATH Month 1 Day 9 Year 1966	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1883		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Wesley Nichols		14. MOTHER'S MAIDEN NAME Henrietta Rideout							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-20-5052		17. INFORMANT Winnie Nichols, Federalsburg, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		Aspiration pneumonia Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
		(b) DUE TO				2 yrs			
		(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 18 Dec 1965 to 9 Jan 1966, that (II) (we) last saw the deceased alive on 8 Jan 1966, and that death occurred at 10 AM, from the causes and on the date stated above.						22b. DATE SIGNED 1-11-66			
22a. SIGNATURE Stephen P. Garney		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Washington Cemetery		23d. LOCATION (City, town or county) (State) Near Hurlock, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
J.J. Hampton & Son		Federalsburg, Md.							
VR A15 (4) 20M 1/65									

~~Montgomery~~
~~Montgomery~~

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

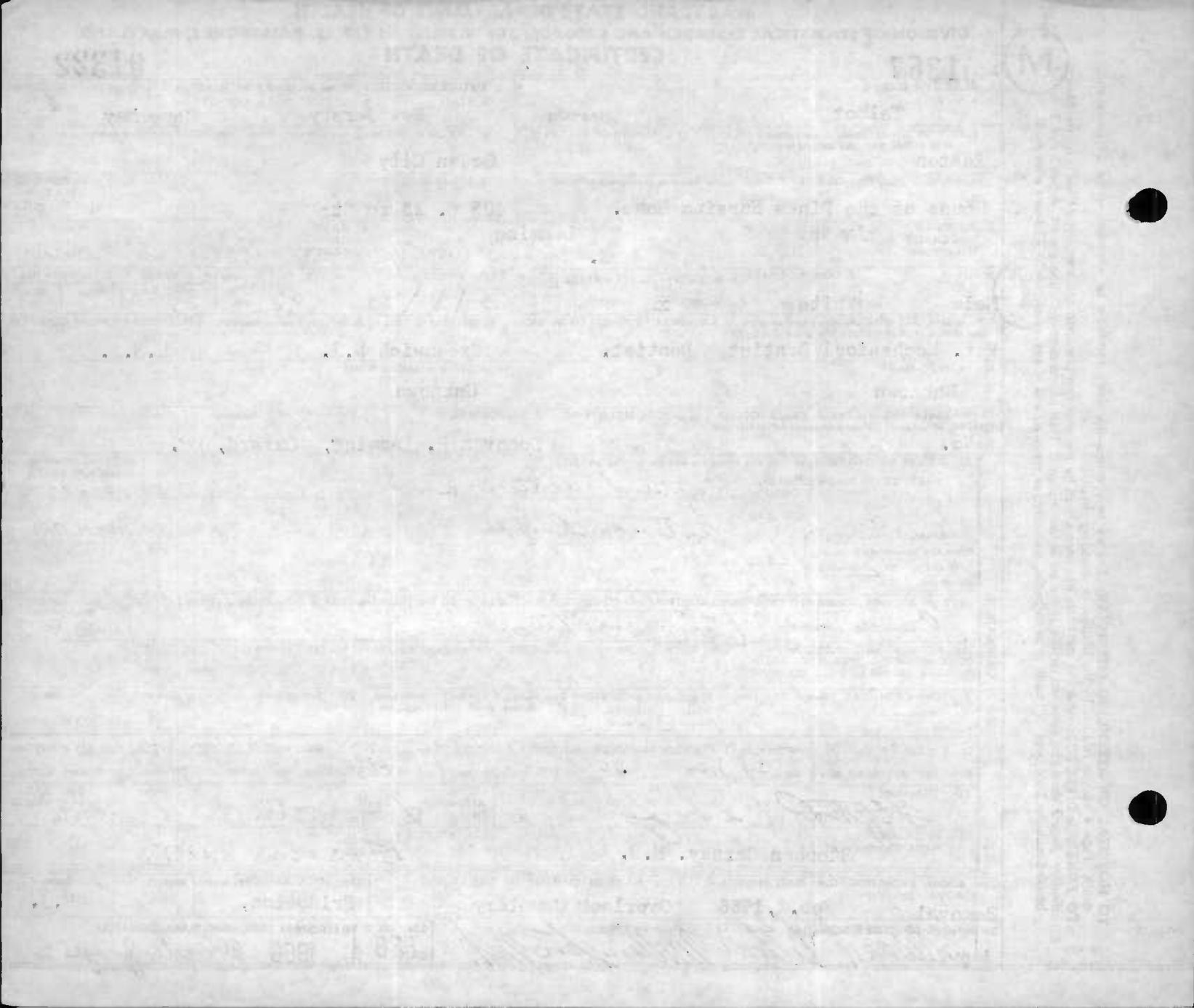
01367

011322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb		a. STATE New Jersey			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House of the Pines Nursing Home.				b. COUNTY Cape May			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) James James Leaming S. Leaming		4. DATE OF DEATH 5 Jan. 29 1966		Month Jan.		Dey 29	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 / 8 / 73	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mechanical Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentist.		11. BIRTHPLACE (County & State, or foreign country) Greenwich N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Donovan R. Leaming, Oxford, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Ruptured aortic aneurysm 451X DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 10 hour Marv yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Carcinoma of the rectum							
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1. Dee, 1965 to 29 Jan, 1966, that (I) (we) last saw the deceased alive on 29 Jan 1966, and that death occurred at 6 PM, from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Easton, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1. Dee, 1965 to 29 JAN, 1966, that (I) (we) last saw the deceased alive on 29 Jan 1966, and that death occurred at 6 PM, from the causes and on the date stated above.						22b. DATE SIGNED 1-29-66	
22e. SIGNATURE Stephen Carney		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Stephen Carney. M.D.		22d. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Feb. 2, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Overlook Cemetery		23d. LOCATION (City, town or county) Bridgeton, (State) N.J.	
24 FUNERAL DIRECTOR'S SIGNATURE Edward Ellsworth Millington Jr.		ADDRESS Millington, Md.		25e. REC'D BY REGISTRAR DATE FEB 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01368 01323

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>			c. LENGTH OF STAY IN 1b MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Dutchman's Lane</i>			e. STREET ADDRESS <i>Dutchman's Lane</i>		
3. NAME OF DECEASED (Type or print) <i>Lulu May Marvel</i>			First	Middle	Last
4. DATE OF DEATH <i>1/15/1966</i>			Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/28/1888</i>	9. AGE (In years (last birthday) <i>78 yrs.</i>	10. IF UNDER 1 YEAR Months <i>X</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Robert James</i>			14. MOTHER'S MAIDEN NAME <i>Rebecca Griffin</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO.	17. INFORMANT <i>161-16-3914 A. Raymond Marvel, Easton, Md.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH <i><48 hrs.</i>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>465X</i>			Massive pulmonary embolism		
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Metastatic neoplasm</i>					
20a. ACCIDENT WAS UNOVERTING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>65</i> , to <i>1-5</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>1-5</i> 19 <i>66</i> , and that death occurred at <i>5 PM</i> M, from the causes and on the date stated above.			22b. DATE SIGNED <i>1-7-66</i>		
22a. SIGNATURE <i>Robert W. Trevor</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trevor</i>			22d. ADDRESS <i>RD 3 Easton, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/8/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill</i>	23d. LOCATION (City, town or county) (State) <i>Easton, Md.</i>	
24. FUNERAL DIRECTOR <i>MURICE E. NEUNAM & SON, Easton, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>JAN 12 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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01369

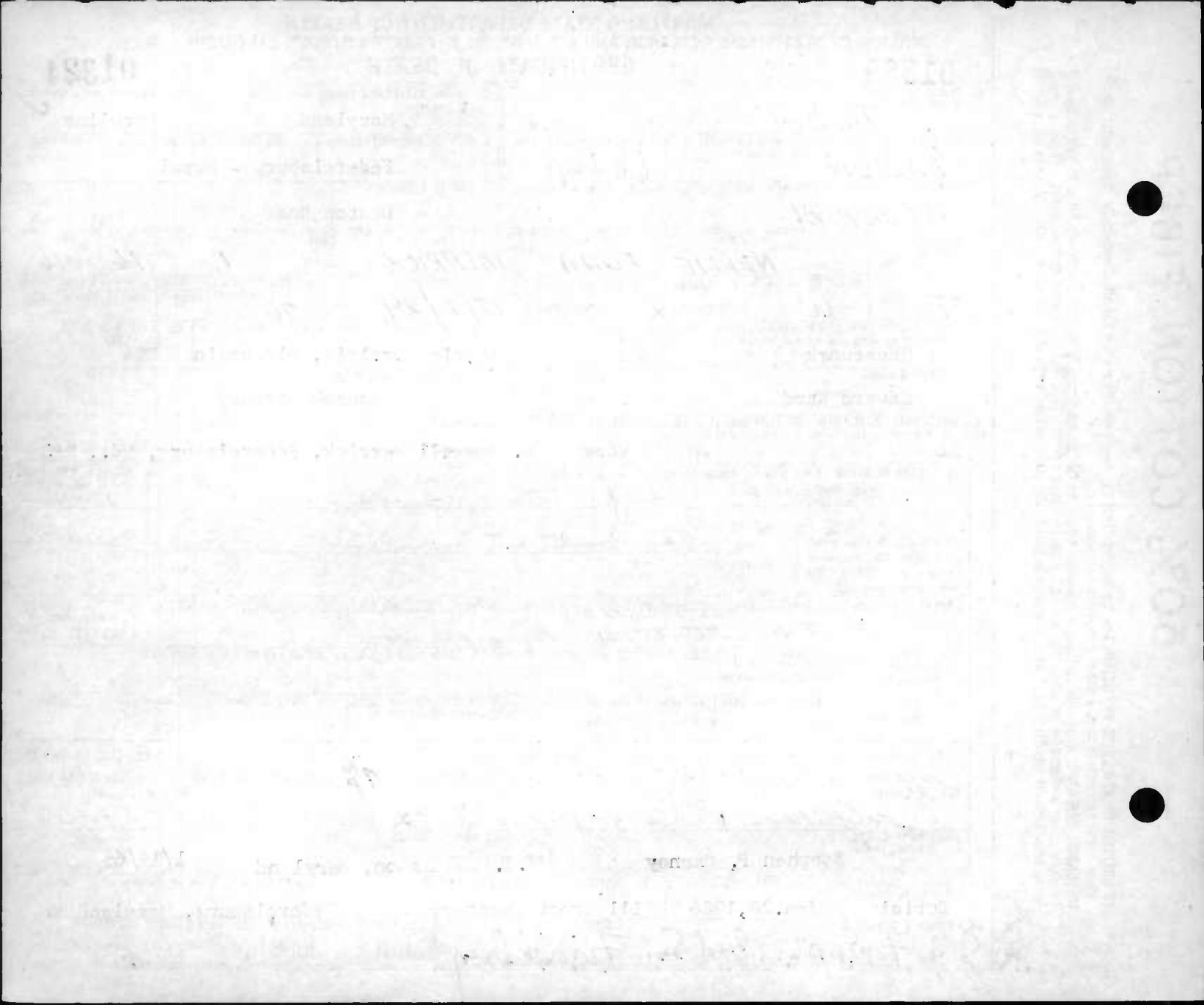
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

111324

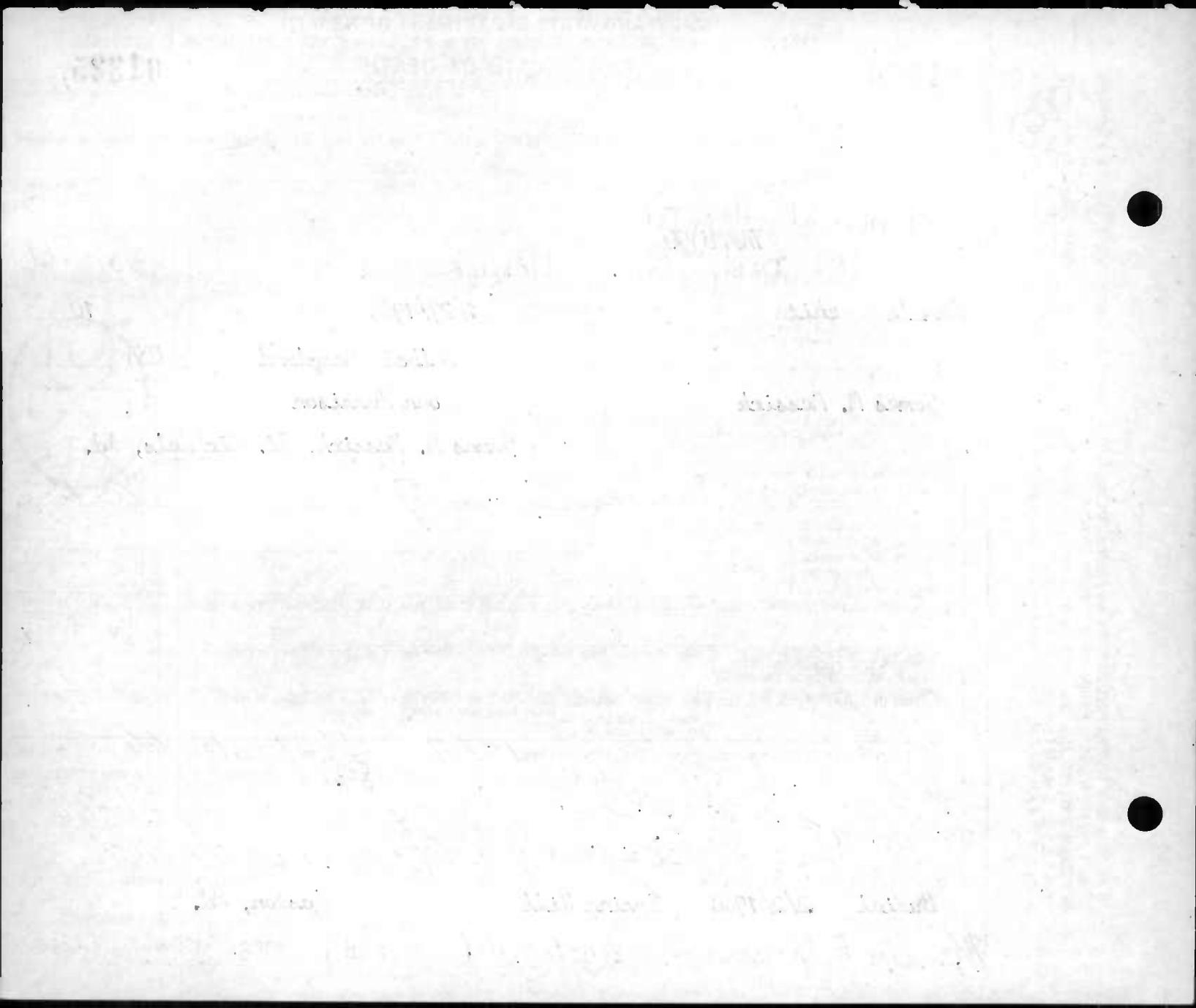
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	c. LENGTH OF STAY IN 1b <i>18 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg - Rural 05 - 2</i>	d. STREET ADDRESS <i>Denton Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>MEMORIAL</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>NELLIE EDNA</i>	First MIDDLE <i>MERRICK</i>	4. DATE OF DEATH <i>1 16 1966</i>	Month Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>12/7/89</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Spring Prairie, Wisconsin</i>	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME <i>Edward Ward</i>	14. MOTHER'S MAIDEN NAME <i>Hannah Starkey</i>	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT E. Russell Merrick, Federalsburg, Md., RFD	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspergillosis pneumonia</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>334X</i> <i>Cerebral arteriosclerosis</i> (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Gastro-intestinal hemorrhage</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-29-1966</i> to <i>1-16-1966</i> , that (I) (we) last saw the deceased alive on <i>1-16-1966</i> , and that death occurred at <i>7 p.m.</i> M, from the causes and on the date stated above.				
22a. SIGNATURE <i>Stephen P. Carney</i>	22b. DATE SIGNED <i>1-19-66</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>	M.D.	22d. ADDRESS <i>Easton, Maryland</i>	1/19/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 20, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery	23d. LOCATION (City, town or county) Federalsburg, Maryland	(State)
24. FUNERAL DIRECTOR <i>J. J. Trampton and Son</i>	ADDRESS <i>Federalsburg</i>	25a. REC'D BY REGISTRAR JAN 24 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
01370				Item #2 info. taken from birth cert. 01325											
1. PLACE OF DEATH a. COUNTY Talbot				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 20-1											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital 78				d. STREET ADDRESS 7 Judas St.											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input type="checkbox"/>				3. NAME OF DECEASED (Type or print) (A) Baby Girl Messick		Middle	Last	4. DATE OF DEATH	Month	Day	Year				
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/1966	9. AGE (In years last birthday) yrs. 10	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	10	1966					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James M. Messick															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 776X				16. SOCIAL SECURITY NO.				17. INFORMANT Joan Harrison				Address James M. Messick, St. Michaels, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIACY 19. INTERVAL BETWEEN ONSET AND DEATH															
IMMEDIACY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 776X				(b) DUE TO				(c) DUE TO				WORKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> p.m. 19				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/29/1966 to 1/30/1966, that (I) (we) last saw the deceased alive on 1/30/1966, and that death occurred at 8:30 AM, from the causes and on the date stated above.				22b. DATE SIGNED 2/2/66											
22a. SIGNATURE				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 2/2/66							
22c. PHYSICIAN'S NAME (TYPE) Lucy M. Reeser				22d. ADDRESS St. Michaels, Md.											
23a. BURIAL, CREMATION, REMOVAL. (Specify) Burial				23b. DATE THEREOF 2/2/1966				23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill				23d. LOCATION (City, town or county) (State) Easton, Md.			
24. FUNERAL DIRECTOR Maurice F. Neumann, Jr. ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE Charles Judge				DATE FEB 7 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. ^{Pages 1 and 2} ^{2 hours after death.}

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
Item #2 Info. taken from birth certificate															
2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)															
a. STATE Maryland															
b. COUNTY Talbot															
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton															
30-1															
d. STREET ADDRESS 7 Judas St.															
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) (B) BABY LYNN Middle Last Name Messick Month 1 - Day 30 Year 1966															
4. DATE OF DEATH															
5. SEX Female white 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1/29/1966 9. AGE (In years last birthday) IF UNDER 1 YEAR yrs. Months Days Hours Min. 9															
WIDOWED <input type="checkbox"/> DIVORCED															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James M. Messick															
14. MOTHER'S MAIDEN NAME Joan Harrison															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address James M. Messick, St. Michaels, Maryland															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMEDIACY 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH 9 hrs.															
776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-29, 1966, to 1-30, 1966, that (I) (we) last saw the deceased alive on 1-30, 1966, and that death occurred at 7 AM, from the causes and on the date stated above.															
22a. SIGNATURE															
22b. DATE SIGNED 2-2-66															
22c. PHYSICIAN'S NAME (Type) Raym Reeser, St. Michaels Md															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/2/1966				23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill				23d. LOCATION (City, town or county) (State) Easton, Md.			
24. FUNERAL DIRECTOR ADDRESS															
25a. REC'D BY REGISTRAR FEB 7 1966															
25b. REGISTRAR'S SIGNATURE Charles Judge															

8210

W.M. Voss
Hornell, N.Y.
July 20, 1908

Dear Sirs:

I have the pleasure to advise you that I have just received your letter of July 10th, and will forward it to Mr. C. L. Shantz, who will be able to give you all the information you desire.

Very truly yours,

W. M. Voss

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
01372				11327								
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>								
c. LENGTH OF STAY IN 1b <i>47 years</i>				d. STREET ADDRESS <i>20-1</i>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Elizabeth V. Newnam</i>				First	Middle	Last	4. DATE DF DEATH <i>1/19 1966</i>	Month	Day	Year		
5. SEX <i>Female</i>				6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/18/1876</i>	9. AGE (In years last birthday) <i>89 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Samuel R. Valliant</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Leonard</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>				17. INFORMANT <i>Mrs. Sara V. Benson, Oxford, Md.</i>				Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>								
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary atherosclerotic heart disease</i>				(c) <i>(?)</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cereumina of the pancreas</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>July 1966, to 19 Jan 1966, that (I) (we) last saw the deceased alive on 18 Jan 1966, and that death occurred at 9P M, from the causes and on the date stated above.</i>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20d. INJURY OCCURRED <i>While at work</i>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>factory, street, office bldg., etc.</i>				20f. (City or town) <i>Easton</i> (County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>July 1966</i> , to <i>19 Jan 1966</i> , that (I) (we) last saw the deceased alive on <i>18 Jan 1966</i> , and that death occurred at <i>9P M</i> , from the causes and on the date stated above.				22b. DATE SIGNED <i>20 Jan 1966</i>								
22a. SIGNATURE <i>Maurice E. Newnam</i>				22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>				22d. ADDRESS <i>Caston, Maryland 21601</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1/22/1966</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill</i>				23d. LOCATION (City, town or county) <i>Easton, Md.</i> (State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>MAURICE E. NEWNAM & SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR <i>JAN 24 1966</i>								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01373 11328

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

01373

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
Talbot MARYLAND		a. STATE <input checked="" type="checkbox"/> Md	b. COUNTY <input type="checkbox"/> Dor			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input type="checkbox"/> c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input type="checkbox"/>				
Fostoria 12 days		Harlock 09-2				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <input type="checkbox"/>		d. STREET ADDRESS <input type="checkbox"/>				
Memorial		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print)		First <i>Glen</i>	Middle <i>Mari</i>			
Last <i>Palmer</i>		4. DATE OF DEATH	Month <i>1</i> Day <i>29</i> Year <i>1966</i>			
5. SEX <input checked="" type="checkbox"/> Male		6. COLOR OR RACE <input checked="" type="checkbox"/> White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input type="checkbox"/>		10b. KIND OF BUSINESS OR INDUSTRY <input type="checkbox"/>				
Farming - Road Grading		11. BIRTHPLACE (County & State, or foreign country) <input type="checkbox"/> 12. CITIZEN OF WHAT COUNTRY <input checked="" type="checkbox"/> USA				
13. FATHER'S NAME <i>Irving Palmer</i>		14. MOTHER'S MAIDEN NAME <i>Hilda Grupe</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <input type="checkbox"/>				
		Address <i>Mrs Doris Palmer, Harlock, Md</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coxiella et heid of</i> 157x DUE TO <i>Rabies</i>						
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	20f. (City or town) <input type="checkbox"/>	(County) <input type="checkbox"/>	(State) <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , to <i>1966</i> , that (I) (we) last saw the deceased alive on <i>1966</i> and that death occurred at <i>428</i> M, from the causes and on the date stated above.						
22a. SIGNATURE <i>Charles J. Schmidt</i>		22b. DATE SIGNED <i>29 Jan 66</i>				
22c. PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		22d. ADDRESS <i>Conton, Md</i>				

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Funeral</i>	23b. DATE THEREOF <i>2/2/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>East New Market</i>	23d. LOCATION (City, town or county) <i>East New Market, Md</i> (State) <i>MD</i>
24a. FUNERAL DIRECTOR <i>Charles J. Schmidt by East New Market</i>	25a. REC'D BY REGISTRAR <i>Feb 3 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01374		11320				
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>St. Michaels (rural)</i>		b. COUNTY <i>Talbot</i>				
c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Rio Vista Nursing Home</i>		d. STREET ADDRESS <i>381 Glebe Road</i>				
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Pritchard</i>		First	Middle			
4. DATE OF DEATH DF <i>1/23 1966</i>		Last	Month Day Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>12/22 1877</i>		9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>				
11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Isaac Kirkman</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Saulsbury</i>				
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>218-01-8629 Mrs. James Allen, Jr., Easton, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4501</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>months</i> <i>5 yr.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>300a</i>	20f. (City or town) <i>Easton</i>	(County) <i>Md.</i>	(State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>3 Dec 1965</i> to <i>23 Jan 1966</i> , that (I) (we) last saw the deceased alive on <i>22 Jan 1966</i> , and that death occurred at <i>20:57 PM</i> , from the causes and on the date stated above.						
22a. SIGNATURE <i>Renee Abbott</i>		22b. DATE SIGNED <i>1-26-66</i>				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS				
23a. BURIAL, CREMATION, OR BURIAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/26/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill</i>	23d. LOCATION (City, town or county) (State) <i>Easton, Md.</i>		
24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM & SON, Easton, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>JAN 26 1966</i>	25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>				b. COUNTY <i>Queen Anne</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>7 hrs.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GRASONVILLE 12-2</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>James</i>	Last <i>Rada</i>	4. DATE OF DEATH <i>JAN. - 5 - 1966</i>	Month	Day	Year					
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 2 - 1895</i>	9. AGE (in years last birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter</i>	14. KIND OF BUSINESS OR INDUSTRY <i>MARYLAND</i>	CITIZEN OF WHAT COUNTRY <i>USA</i>		
15. FATHER'S NAME <i>JAMES RADA</i>		16. SOCIAL SECURITY NO. <i>217-09-4235</i>		17. INFORMANT <i>MRS. SARAH RADA - GRASONVILLE MD.</i>	Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the esophagus</i> DUE TO 150X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____													
INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>1 Jan 1966</i> , to <i>5 Jan 1966</i> , that (I) (we) last saw the deceased alive on <i>5 Jan 1966</i> , and that death occurred at <i>3 AM</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>Stephen P. Carney</i>													
22b. DATE SIGNED <i>5 Jan 66</i>													
22c. PHYSICIAN'S NAME (Type) <i>STEPHEN P. CARNEY</i>				22d. ADDRESS <i>EASTON MARYLAND</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>JAN. 7</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>STEVENSVILLE</i>	23d. LOCATION (City, town or county) <i>STEVENSVILLE M.D.</i>									
24. FUNERAL DIRECTOR <i>Edgar L. Lane CHURCH Hill, MD.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>JAN 11 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

06911

representatives of animals

birds

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

executed within 24 hours after death.

1 Page 4 may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01376

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)	
<i>Talbot</i>		a. STATE <i>MARYLAND</i> b. COUNTY <i>CAROLINE</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>6 hrs. 5 min.</i>	
<i>EASTON</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <i>Rural Denton 05-2</i>	
e. IS RESIDENCE ON A FARM?		e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>FLOYD</i>	Middle <i>T</i>
4. DATE OF DEATH		Last <i>RIGGIN</i>	Month <i>JULY</i> Day <i>16</i> Year <i>1966</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>JULY 16, 1901</i>		9. AGE (In years last birthday) <i>64 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>FISH PEDDLER</i>	
11. BORN IN PLACE (County & State, or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JOHN RIGGIN</i>		14. MOTHER'S MAIDEN NAME <i>EMMA MORRIS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>17. INFIRMITY</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 hrs.</i>	
330X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i> </i> DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Denton</i> (County) <i>Caroline</i> (State) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>13 Jan</i> , 19 <i>66</i> , to <i>13 Jun</i> , 19 <i>66</i> , that (II) (we) last saw the deceased alive on <i>13 Jan</i> , 19 <i>66</i> , and that death occurred at <i>405</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Stephen P. Carney</i>		22b. DATE SIGNED <i>14 Jan 66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Easton, Maryland</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan 15 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>SHAD POINT</i>	
23b. DATE THEREOF <i>Jan 15 1966</i>		23d. LOCATION (City, town or county) <i>NEAR SALISBURY MD.</i>	
24. FUNERAL DIRECTOR <i>WDR GIL MOORE</i>		ADDRESS <i>DENTON, MD.</i>	25a. REC'D BY REGISTRAR <i>JAN 18 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>				c. LENGTH OF STAY IN 1b <i>Lifetime</i>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First <i>William James Roe, Sr.</i>	Middle	Last	4. DATE OF DEATH <i>1/15 1966</i>	Month	Day	Year			
5. SEX <i>male</i>			6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/10/1896</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>00</i>	11. IF UNDER 24 HRS. Days <i>00</i>	12. IF UNDER 24 HRS. Hours <i>00</i>	13. IF UNDER 24 HRS. Min. <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Roe</i>				14. MOTHER'S MAIDEN NAME <i>Sarah L. Frampton</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>212-16-7751</i>				17. INFORMANT <i>Mrs. W. J. Roe, Tilghman, Md.</i>				Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> 418- DUE TO DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>9-11, 1965</i> , to <i>12-14, 1965</i> , that (I) (we) last saw the deceased alive on <i>12-14, 1965</i> , and that death occurred at <i>12-14, 1965</i> M, from the causes and on the date stated above.												
22a. SIGNATURE <i>S. Krech Jr.</i>				22b. DATE SIGNED <i>1-7-66</i>								
22c. PHYSICIAN'S NAME (Type) <i>S. Krech Jr.</i>				22d. ADDRESS <i>EASTON, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>1/7/1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Sherwood Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Sherwood, Md.</i>				
24. FUNERAL DIRECTOR <i>MURRAY E. NEUNAM & SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>10 1966</i>								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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Indigo.

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																					
CERTIFICATE OF DEATH																					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE																	
Talbot				MARYLAND																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b																	
Easton				61 $\frac{1}{2}$ hours																	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
Memorial Hospital																					
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year											
Mr. Roland Hill Seymour							1	27	19	66											
5. SEX				6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.												
MALE				WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG 1, 1911	54 yrs.	Months	Days	Hours											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?									
WATERMAN				COMMERCIAL				ST. MICHAELS, MD				U.S.A.									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME																	
DANIEL L. SEYMOUR				Rowena Mae Jackson																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address									
—				—				Mrs. Rowena Kilkenny, NEWCOMB, Ind.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																					
581.0																					
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.																					
(b) <i>Cirrhosis of liver</i>																					
(c) <i>Multiple pulmonary obstructions</i>																					
INTERVAL BETWEEN ONSET AND DEATH																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
19																					
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>13 July 1966</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.																					
22a. SIGNATURE <i>Edgar Schmidt</i>																					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				22b. DATE SIGNED <i>27 Jan 66</i>													
E.C.H. Schmidt				Easton, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City, town or county) (State)									
Burial Jan 29 1966								Oliver Cemetery				St. Michaels, Md									
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
J.W. Harrison, St. Michaels, Md								FEB 1 1966				Charles Judge									
DATE																					

1881

5722

TOOK BOOK
AUGUST 10, 1901
DANIEL F. DEWAN
GARDEN CITY, KANSAS
JULY 20, 1901
MCKEEGAN
(Continued)
WHITE MAPLE

2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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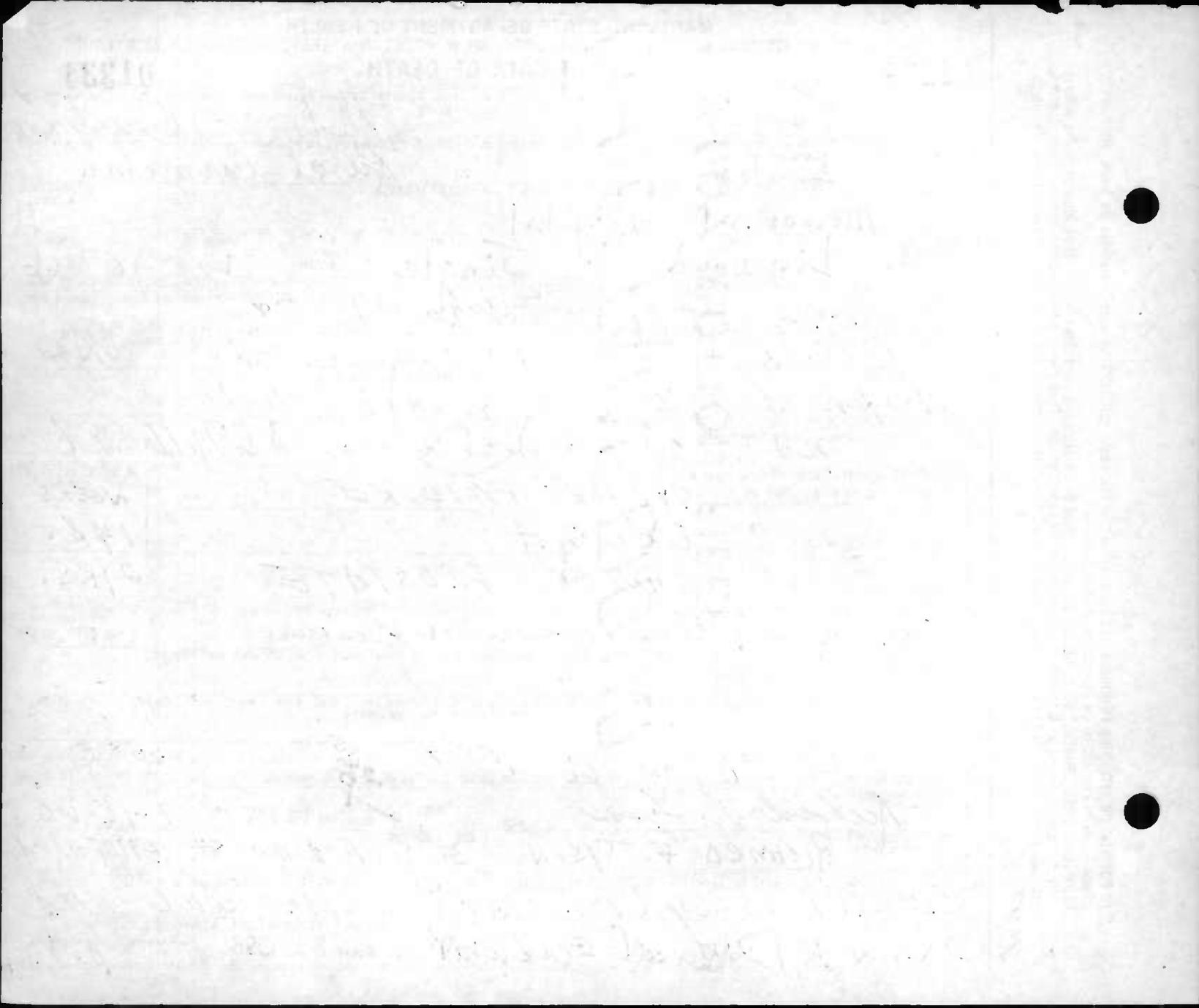
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

01379

CERTIFICATE OF DEATH

011334

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Queen Anne</i>										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Carmichael</i>	d. STREET ADDRESS <i>17-2</i>										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) <i>Linwood</i>	First <i>Linwood</i>	Middle <i></i>	Last <i>Single</i>	4. DATE OF DEATH Month <i>1</i>	Day <i>18</i>	Year <i>1966</i>							
5. SEX <i>M</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 11, 1887</i>	9. AGE (In years last birthday) yrs. <i>78</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. FATHER'S NAME <i>Retired</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Wilmer</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-01-2474</i>	17. INFORMANT <i>Helen Freeman</i>	Address <i>Wye Mills, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i>				NEART FAILURE					WEEKS				
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>UREMIA</i>									1YR.				
(c) <i>CANCER PROSTATE</i>									2YRS.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension Cardiovascular Disease</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)					
21. I certify that (I) this hospital attended the deceased from <i>109</i> , 19 <i>65</i> , to <i>1966</i> , that (II) we last saw the deceased alive on <i>18 JUN 1966</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.				22b. DATE SIGNED <i>1-18-66</i>									
22a. SIGNATURE <i>Richard F. Tyson</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-18-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>RICHARD F. TYSON</i>				22d. ADDRESS <i>365 Aurora St., EASTON, MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 1-22-66</i>		23b. DATE THEREOF <i>Carmichael Cem</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Carmichael</i>		23d. LOCATION (City, town or county) <i>Ed.</i>		(State)					
24. FUNERAL DIRECTOR <i>James B. Dickey Easton</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE							
DATE <i>JAN 21 1966</i>				DATE <i>JAN 21 1966</i>									



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01380 01335

1. PLACE OF DEATH a. COUNTY <i>Falbot</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	c. LENGTH OF STAY IN 1B <i>DOA @ 12 pm</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>	d. STREET ADDRESS <i>4303 Greenhill Ave.</i>						
3. NAME OF DECEASED (Type or print) <i>Timothy Michael</i>	4. DATE OF DEATH Last Month Day Year <i>Smith 1 27 1966</i>						
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>-10-56</i>	9. AGE (In years last birthday) <i>10 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	11. IF UNDER 24 HRS. Months Days Hours Min. <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>student</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Md. Baltimore</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Elmer Augustus Smith</i>	14. MOTHER'S MAIDEN NAME <i>Patricia Michoakti</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Elmer A. Smith, father, above</i>	Address <i></i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7531</i>				INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Grand Mal Seizure</i>				8 am			
DUE TO (c) <i>Pneumonia</i>				Brain			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i></i>				Birth			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i></i>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>H. B. Plummer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>Baltimore, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/31/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Redeemer Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> 3331 Brehms Lane		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>Feb 1 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

adult female Nitrocaeca sp. sp.
ovipositor terminal dilated spine

spine terminal

(255) general overall shape

shape

general shape

general shape

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04390

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL TRAPPE</i>		b. COUNTY <i>TALBOT</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <i>133 S. WASHINGTON</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ROBERT</i>		First <i>G.</i>	Middle <i>Snyder</i>
4. DATE OF DEATH <i>JAN 17⁺ 1966</i>		Last <i>SNYDER</i>	Month Day Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>MAY 8, 1921</i>		9. AGE (In years last birthday) <i>44 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Roads Comm.</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>COUNTRY?</i>	
13. FATHER'S NAME <i>Chester W. Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Grace Schneider</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>217-60-5640</i>	
17. INFORMANT <i>Mr. William Snyder</i>		Address <i>5600 Loch Raven Boulevard</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>DROWNING</i>		INTERVAL BETWEEN ONSET AND DEATH	
975 X Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c)			
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Body recovered Choptank River Mar 19, 1966</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>JAN 17⁺ 19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. <i>Choptank R.</i>
20f. (City or town) <i>Choptank R.</i>		(County) <i>Choptank R.</i>	
(State) <i>Choptank R.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Lewis J. Welty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Lewis J. Welty</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <i>3-19-66</i>			
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/21/1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Pikesville, Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. J. Tichner & Sons mort. & pa. ave.</i>		ADDRESS <i>Baltimore, Md. 17</i>	
		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

WATSON & EPI

WATSON & EPI

in 1591, 3 AM

CB 1591

WATSON & EPI

1
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY <i>Talbot</i>				a. STATE Maryland b. COUNTY Talbot											
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>D.O.A.</i>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>				e. STREET ADDRESS <i>20-1</i>											
3. NAME OF DECEASED (Type or print) JAMES EARL STEVENS				First	Middle	Last	4. DATE OF DEATH 1 - 4 1966	Month	Day	Year					
5. SEX male				6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/1902	9. AGE (in years last birthday) 63 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caretaker</i>				11b. KIND OF BUSINESS DR INDUSTRY <i>farming</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Harvey Stevens</i>				14. MOTHER'S MAIDEN NAME <i>Evelyn Lyons</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 217-28-3050				17. INFORMANT Mrs. J. Earl Stevens, Easton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> INTERVAL BETWEEN ONSET AND DEATH 4200 <10 min.															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> UNKNOWN (c) <i>with angina pectoris</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on D.O.A. 1-4 1966 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.															
22a. SIGNATURE <i>Robert W. Trevor</i>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trevor</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF 1/6/1966				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Oxford</i>				23d. LOCATION (City, town or county) (State) Oxford, Md.			
24. FUNERAL DIRECTOR <i>Maurice E. Newman & Son</i>				25a. REC'D BY REGISTRAR DATE 1 JAN 6 1966								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

soil

hardwood

loam soil

soft

leached, oxidized

gravel

soil

soil layer

oxidized

weathered

soil, weathered, well-drained

soil

KH 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN TB <u>DoA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton (rural)</u> d. STREET ADDRESS <u>RFD # 1 Box 115 M</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u> 99				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Paul Mitchell</u>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/1905</u>	9. AGE (In years last birthday) <u>60 yrs.</u>	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>mechanical civil</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Little Sioux Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Bennett M. Terry</u>				14. MOTHER'S MAIDEN NAME <u>Murtle Byers</u>				Address <u>Mrs. Paul M. Terry, RFD #1, Easton, Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>558-07-2455</u>				17. INFORMANT <u>Mrs. Paul M. Terry</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10A M</u>		20f. (City or town) <u>Easton</u> (County) <u>Caroline</u> (State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1964</u> to <u>Jan 1966</u> that (I) (we) last saw the deceased alive on <u>20 Jan 1966</u> , and that death occurred at <u>10A M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Stephen P. Canney</u>				22b. DATE SIGNED <u>1-31-66</u>							
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Canney</u>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>2/7/1966</u>				23c. NAME OF CEMETERY OR CREMATORIAL <u>Green Mount</u>			
24. FUNERAL DIRECTOR <u>Maurice E. Newland Son</u>				ADDRESS <u>Easton, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 7 1956</u>			
VR A15 (4) 20M 1/65				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

171

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most abu

sp. nov.

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sp. nov.

coll. 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01383

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01388

1. PLACE OF DEATH

a. COUNTY

TALBOT

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL EASTON

c. LENGTH OF STAY IN 1b

3 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month JAN

Day 1

Year 1966

5. SEX

6. COLOR DR RACE

7. MARRIED

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

RODERICK WILCOX

14. MOTHER'S MAIDEN NAME

BERTHA PETERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

(If yes give war or dates of service)

YES W.W.I

16. SOCIAL SECURITY NO.

275-03-8737

17. INFORMANT

MRS. C.P. WILCOX

Address

P.O. EASTON, MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

5400

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Gastrointestinal hemorrhage

Probable peptic ulcer

INTERVAL BETWEEN
DNSET AND DEATH
2 hours

unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Warfarin therapy. Recent myocardial infarction

19. WAS AUTOPSY
PERFMD?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 June, 1965, to 1 Jan, 1966, that (I) (we) last saw the deceased alive on 2 Dec 1965, and that death occurred at 7:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Stephen Carey
STEPHEN P. CAREY22b. DATE SIGNED
M.D. ATTENDING PHYS.
MED. DIRECTOR STAFF PHYS. 22d. ADDRESS
EASTON, MD.23a. BURIAL, CREMATION
REMOVAL (Specify)

23b. DATE THEREOF JAN 5, 1966

23c. NAME OF CEMETERY OR CREMATORIUM
CEDAR HILL23d. LOCATION (City, town or county)
WASHINGTON (State) D.C.

24. FUNERAL DIRECTOR

ADDRESS
EASTON, MD.

25a. REC'D BY REGISTRAR JAN 5, 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge

10.000

10000

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

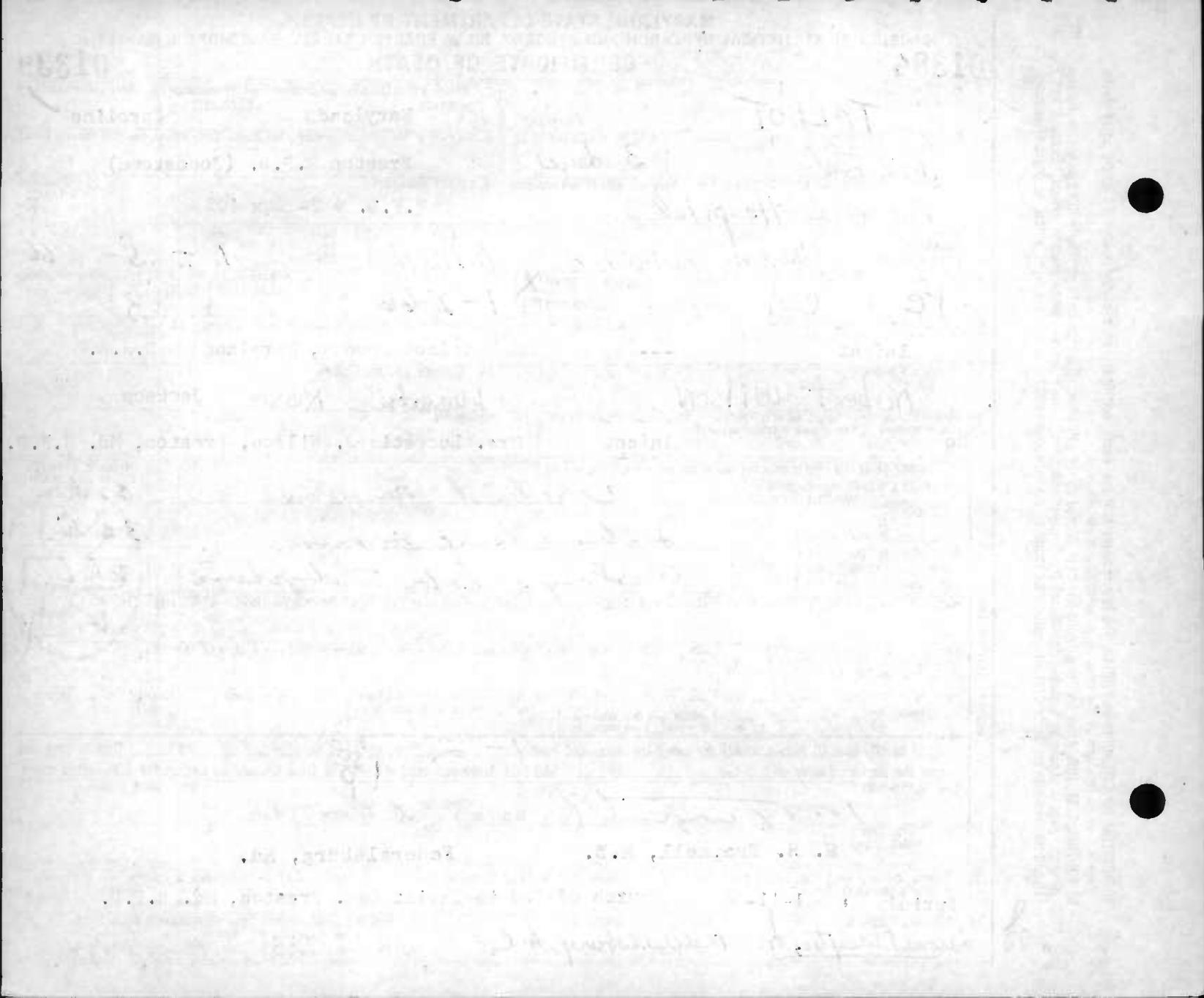
Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01384 01339

1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	c. LENGTH OF STAY IN lb <i>3 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston R.F.D. (Jonestown) 05-2</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS <i>R.F.D. # 2- Box 102</i>			
3. NAME OF DECEASED (Type or print) <i>Gloria Lucretia</i>	First Middle Last <i>Gloria Lucretia Wilson</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE DF DEATH <i>1 - 5 - 1966</i>	Month Day Year				
5. SEX <i>F</i>	6. COLOR OR RACE <i>Co.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-2-66</i>	9. AGE (in years last birthday) yrs. <i>3</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>3</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Talbot county, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Robert Wilson</i>	14. MOTHER'S MAIDEN NAME <i>Lucretia Rose Jackson</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>Infant</i>	17. INFORMANT <i>Mrs. Lucretia J. Wilson, Preston, Md. R.F.D.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN DNSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7620</i>			<i>Cerebral anoxia</i> <i>32 hrs</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Dinta uterine anoxia</i> (c) <i>Prolonged labor - dystocia</i>			<i>32 hr</i> <i>36 hr labr</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1-2</i> , 19 <i>66</i> , to <i>1-5</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>10</i> A.M., from the causes and on the date stated above.	22b. DATE SIGNED <i>1967 Trapnell</i>				
22a. SIGNATURE <i>1967 Trapnell</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <i>R. H. Trapnell, M.D.</i>	22d. ADDRESS <i>Federalsburg, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1-11-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Church of God in Christ Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Preston, Md. R.F.D.</i>		
24. FUNERAL DIRECTOR <i>None Hampton Jr. Federalsburg, Md.</i>	ADDRESS <i>6-160787</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 17 1956</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



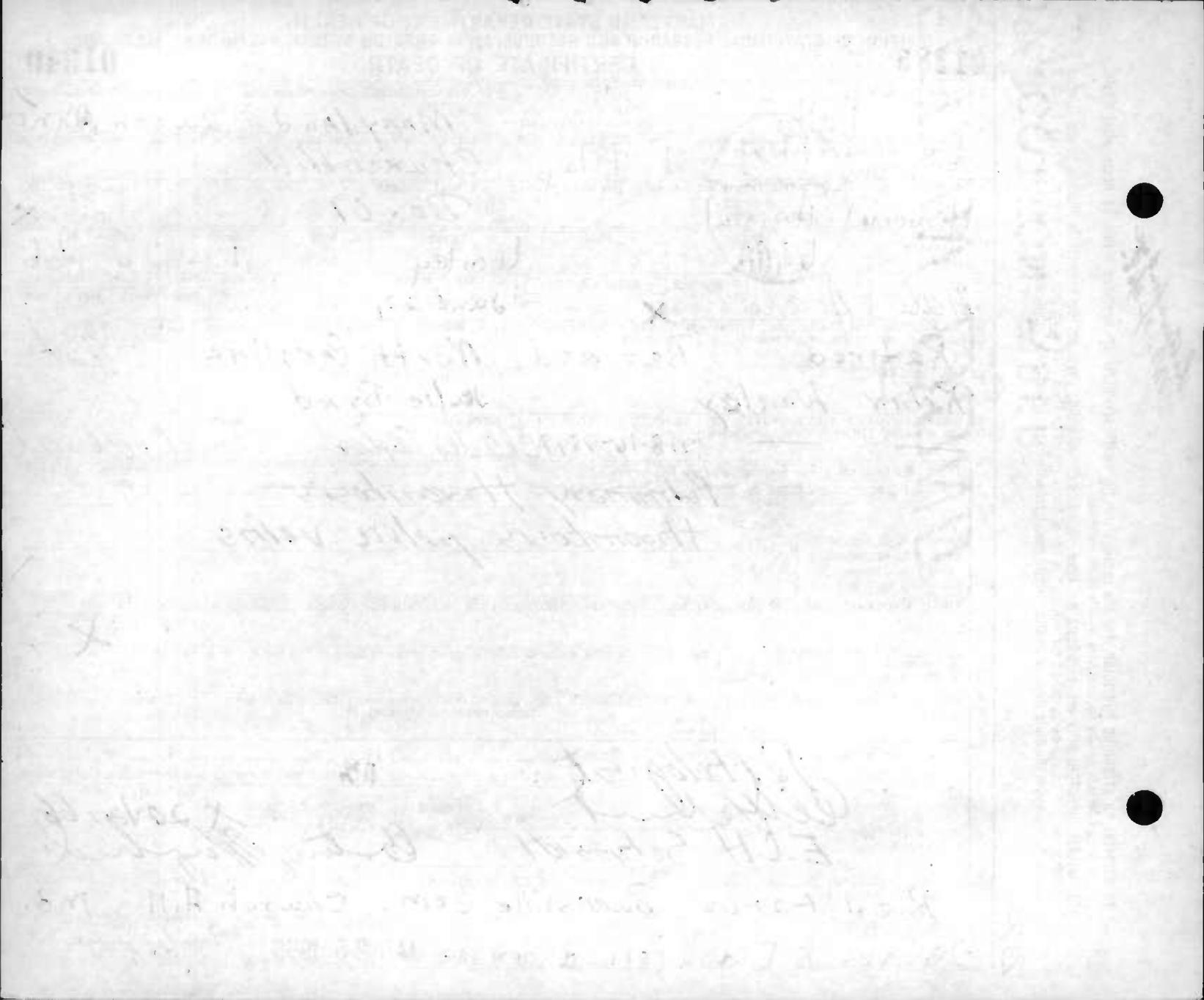
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Items 5, 9 Film 0374 3016-100
01385 01340

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostown</i>	c. LENGTH OF STAY IN 1D <i>7 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Church Hill</i> 17-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS <i>Box 61</i>	
3. NAME OF DECEASED (Type or print) <i>Willis</i>	First <i>W</i>	Middle <i>llis</i>	Last <i>Worley</i>
4. DATE OF DEATH <i>1 - 20 1966</i>	Month <i>1</i>	Day <i>20</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Afro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22, 1896</i>
9. AGE (in years last birthday) <i>69 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Robin Worley</i>		
14. MOTHER'S MAIDEN NAME <i>Julie Byrd</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>—</i>		
16. SOCIAL SECURITY NO. <i>218-16-7849</i>	17. INFORMANT <i>Charles Taylor</i>	Address <i>Church Hill, Md</i>	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary thrombosis</i> 466 X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>thrombosis pelvic veins</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>factory, street, office bldg., etc.</i>
20f. (City or town) <i>—</i>		(County) (State) <i>—</i>	
21. I certify that (I) (We) attended the deceased from _____, 19____, to _____, 19____, that (I) (We) last saw the deceased alive on _____, 19____, and that death occurred at 11:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles H. Schmidt</i>		22b. DATE SIGNED <i>20/12/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		22d. ADDRESS <i>Country, Maryland</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>1-23-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Burrsville Cem</i>		23d. LOCATION (CITY, TOWN OR COUNTY) (STATE) <i>Church Hill Md.</i>	
24. FUNERAL DIRECTOR <i>James B Dashiel Eastbound</i>		ADDRESS <i>—</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 25 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		01341			
1. PLACE OF DEATH a. COUNTY				TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				a. STATE MARYLAND b. COUNTY QUEEN ANNE'S					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				EASTON				c. LENGTH OF STAY IN 1b 15 days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				MEMORIAL HOSPITAL				d. STREET ADDRESS Waltham Farm				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH		Month	Day	Year			
FANNY EARLE WRIGHT										JANUARY 8				1966			
5. SEX				6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
Female				White		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		Feb. 20, 1873		92 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Housewife				Home				Centreville, Q.A.C., Md.				U.S.A.					
13. FATHER'S NAME				William Brundige Earle				14. MOTHER'S MAIDEN NAME				Louisa Stubbs					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
No				220-440-0378				Mrs. FRANCES W. HILLARY				Waltham Farm, Centreville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN DNSE AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X												1-3-66					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of rt. femur																	
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <u>H.P.</u> M, from the causes and on the date stated above.												22b. DATE SIGNED					
22a. SIGNATURE Robert W. Trevor				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) Robert W. Trevor, M.D.				22d. ADDRESS Easton, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 11, 1966				23c. NAME OF CEMETERY OR CREMATORIUM Family Cemetery - Melfield				23d. LOCATION (City, town or county) Centreville, Q.A.C. Md. (State)					
24. FUNERAL DIRECTOR John W. Burton, Burton Bros. Centreville, Md.				ADDRESS								25a. REC'D BY REGISTRAR JAN 14 1966				25d. REGISTRAR'S SIGNATURE Charles Judge	

